Senate File 206 - Introduced

SENATE FILE 206
BY ZAUN

A BILL FOR

An Act relating to medical malpractice liability and insurance coverage in the state and including applicability provisions.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF IOWA:

Section 1. NEW SECTION. **519B.1 Definitions.**

As used in this chapter, unless the context otherwise requires:

1. *"Commissioner"* means the commissioner of insurance or a designee.

2. *"Cost of the periodic payments agreement"* means the amount expended by a health care provider, the health care provider's medical malpractice insurer, the commissioner, or a combination thereof, at the time the periodic payments agreement is made, to obtain a commitment from a third party to make money available for use as future payment, the total of which may exceed the limits provided in section 519B.14.

3. *"Health care provider"* means and includes a physician and surgeon, osteopathic physician and surgeon, dentist, podiatric physician, optometrist, pharmacist, chiropractor, or nurse licensed pursuant to chapter 147, a hospital licensed pursuant to chapter 135B, and a health care facility licensed pursuant to chapter 135C.

4. *"Medical malpractice insurance"* means insurance coverage against the legal liability of the insured and against loss, damage, or expense incident to a claim arising out of the death or injury of any person as the result of negligence or malpractice in rendering professional service by any licensed health care provider.

5. *"Net direct premiums"* means gross direct premiums written on liability insurance as reported in the annual statements filed by insurers with the commissioner, including the liability component of multiple peril package policies as computed by the commissioner, less return premiums for the unused or unabsorbed portions of premium deposits.

6. *"Patient"* means an individual who receives or should have received health care from a health care provider under a contract, express or implied, and includes a person having a claim of any kind, whether derivative or otherwise, as a result of alleged malpractice on the part of a health care provider.

For purposes of this subsection, "derivative" claims include the claim of a parent or parents, guardian, trustee, child, relative, attorney, or any other representative of a patient, including claims for loss of services, loss of consortium, expenses, and other similar claims.

7. *"Periodic payments agreement"* means a contract between a health care provider or the health care provider's medical malpractice insurer and the patient or the patient's estate, under which the health care provider is relieved from possible liability, whether or not some or all of the payments are contingent upon the patient's survival to the proposed date of payment, in consideration of any of the following:

a. A present payment of moneys to the patient or the patient's estate.

b. One or more payments to the patient or the patient's estate in the future.

Sec. 2. NEW SECTION. **519B.2 Application of chapter.**

A health care provider who fails to qualify under this chapter is not covered by this chapter and is subject to liability under the law without regard to this chapter. If a health care provider does not qualify, a patient's remedy against the health care provider is not affected by this chapter.

Sec. 3. NEW SECTION. **519B.3 Qualification of health care providers.**

1. A health care provider qualifies under and is subject to the application of this chapter by doing both of the following:

a. Establishing financial responsibility as provided in section 519B.4.

b. Paying the surcharge assessed as provided in section 519B.5.

2. A health care provider shall establish financial responsibility and pay the surcharge not later than ninety days after the effective date of the medical malpractice insurance policy issued to the provider. Notwithstanding this

requirement, the commissioner may accept a late filing and payment if the filing is accompanied by a penalty amount as set forth by the commissioner by rules adopted pursuant to chapter 17A.

3. Within five business days after the commissioner receives the information and payment required under subsection 1 for the qualification of a health care provider, the commissioner shall notify the health care provider whether the provider is qualified and if the provider is qualified, the date of qualification.

Sec. 4. NEW SECTION. **519B.4 Establishment of financial responsibility.**

A health care provider may establish the financial responsibility of the health care provider and the provider's officers, agents, and employees while acting in the course and scope of their employment with the health care provider in any of the following ways:

1. By filing proof with the commissioner that the health care provider is insured by a policy of medical malpractice insurance in the amount of at least two hundred fifty thousand dollars per occurrence and seven hundred fifty thousand dollars in the annual aggregate, except for the following:

a. If the health care provider is a hospital licensed pursuant to chapter 135B, the minimum annual aggregate amount is as follows:

(1) For hospitals of not more than one hundred beds, five million dollars.

(2) For hospitals of more than one hundred beds, seven million five hundred thousand dollars.

b. If the health care provider is a health care facility licensed pursuant to chapter 135C, the minimum annual aggregate amount is as follows:

(1) For health care facilities with not more than one hundred beds, seven hundred fifty thousand dollars.

(2) For health care facilities with more than one hundred

beds, one million two hundred fifty thousand dollars.

2. By filing and maintaining with the commissioner cash or a surety bond approved by the commissioner in the amounts set forth in subsection 1.

3. *a.* If the health care provider is a hospital, by annually submitting a verified financial statement that, in the discretion of the commissioner, adequately demonstrates that the current and future financial responsibility of the hospital is sufficient to satisfy all potential malpractice claims incurred by the hospital or the hospital's officers, agents, and employees while acting in the course and scope of their employment up to a total of two hundred fifty thousand dollars per occurrence and annual aggregates as follows:

(1) For hospitals of not more than one hundred beds, five million dollars.

(2) For hospitals of more than one hundred beds, seven million five hundred thousand dollars.

b. The commissioner may also require the deposit of security to assure continued financial responsibility under this subsection.

Sec. 5. NEW SECTION. **519B.5 Surcharge.**

1. Beginning January 1, 2018, the commissioner shall assess an annual surcharge on all health care providers in the state who seek to qualify under this chapter, to create a source of moneys for the patient compensation fund.

2. Beginning January 1, 2018, the amount of the annual surcharge shall be one hundred percent of the annual cost to each health care provider of maintaining financial responsibility.

3. Notwithstanding subsection 2, beginning January 1, 2018, the surcharge for a health care provider licensed as a physician under chapter 148 who seeks to qualify under this chapter, shall be calculated as follows:

a. The commissioner shall contract with an actuary who has experience in calculating the actuarial risks posed by

physicians. Not later than July 1 of each year, the actuary shall calculate the median of the premiums paid for medical malpractice insurance to the three malpractice insurance carriers in the state that have underwritten the most malpractice insurance policies for all physicians practicing in the same specialty class in the state during the previous twelve-month period. In calculating the median, the actuary shall consider the following:

(1) The manual rates of the three leading malpractice insurance carriers in the state.

(2) The aggregate credits or debits to the manual rates given during the previous twelve-month period.

b. After making the calculation described in paragraph *"a"*, the actuary shall establish a uniform surcharge for all licensed physicians practicing in the same specialty class. The surcharge shall be based on a percentage of the median calculated in paragraph *"a"* for all licensed physicians practicing in the same specialty class under rules adopted by the commissioner pursuant to chapter 17A. The surcharge shall be sufficient to cover, but not exceed, the actuarial risk posed to the patient compensation fund by physicians practicing in the specialty class.

4. *a.* Notwithstanding subsection 2, beginning January 1, 2018, the surcharge for a health care provider that is a hospital licensed under chapter 135B that seeks to qualify under this chapter shall be established by the commissioner through the use of an actuarial program in an amount that is sufficient to cover, but not exceed, the actuarial risk posed to the patient compensation fund by the hospital.

b. As used in this subsection, *"actuarial program"* means a program used or created by the commissioner to determine the actuarial risk posed to the patient compensation fund by a hospital. The program must be all of the following:

(1) Developed to calculate actuarial risk posed by a hospital, taking into consideration risk management programs

used by the hospital.

(2) An efficient and accurate means of calculating a hospital's malpractice actuarial risk.

(3) Publicly identified by the commissioner by January 1 of each year.

(4) Made available to a hospital's malpractice insurance carrier for purposes of calculating the hospital's surcharge under this subsection.

5. The surcharge shall be collected on the same basis as premiums by each medical malpractice insurer.

6. The surcharges collected shall be remitted to the commissioner for deposit into the patient compensation fund within thirty days after a premium for medical malpractice insurance has been received by an insurer from a health care provider. If a surcharge is not paid as required by this section, the insurer responsible for the delinquency is liable for the surcharge plus a penalty equal to ten percent of the amount of the surcharge, which penalty shall also be deposited into the patient compensation fund.

7. *a.* The commissioner may adopt rules pursuant to chapter 17A establishing all of the following:

(1) The manner of determination of the surcharge for a health care provider who establishes financial responsibility in a manner other than by a policy of medical malpractice insurance.

(2) The manner of payment of the surcharge by such a health care provider.

b. The surcharge calculation established under paragraph "*a*" shall provide comparability in rates for insured and self-insured hospitals. The surcharge shall not exceed the surcharge that would be charged by a medical malpractice insurer if the health care provider electing to establish financial responsibility in this manner had applied to a malpractice insurer for insurance.

8. Beginning July 1, 2020, the annual surcharge shall be set

by rules adopted by the commissioner pursuant to chapter 17A that meet the following requirements:

a. The amount of the surcharge shall be determined based upon actuarial principles and actuarial studies and must be adequate for the payment of claims and expenses from the patient compensation fund.

b. The annual surcharge for qualified health care providers other than physicians licensed under chapter 148 and hospitals licensed under chapter 135B shall not exceed the actuarial risk posed to the patient compensation fund by qualified health care providers and shall not be less than one hundred dollars.

Sec. 6. NEW SECTION. **519B.6 Patient compensation fund.**

1. A patient compensation fund is established under the custody of the treasurer of state and shall consist of payments to the fund as provided by this chapter and any accumulated interest and earnings in the patient compensation fund.

2. The treasurer of state is charged with conservation of the assets of the patient compensation fund. Moneys collected in the fund shall be disbursed only for the purposes stated in this chapter and shall not at any time be appropriated or diverted to any other use or purpose. Except for reimbursements to the attorney general provided for in subsection 4, disbursements from the fund shall be paid by the treasurer of state only upon the written order of the commissioner. The treasurer of state shall invest any surplus moneys of the fund in securities which constitute legal investments for state funds under the laws of this state, and may sell any of the securities in which the fund is invested, if necessary, for the proper administration or in the best interests of the fund.

3. The treasurer of state shall quarterly prepare a statement of the fund, setting forth the balance of moneys in the fund, the income of the fund, specifying the source of all income, the payments out of the fund, specifying the various items of payments, and setting forth the balance of the fund

remaining to its credit. The statement shall be open to public inspection in the office of the treasurer of state.

4. *a.* The attorney general shall appoint a staff member to represent the treasurer of state and the patient compensation fund in all proceedings and matters arising under this chapter. The attorney general shall be reimbursed up to two hundred fifteen thousand dollars annually from the fund for services provided related to the fund. The commissioner of insurance shall consider the reimbursement to the attorney general as an outstanding liability when making a determination of the amount of the surcharge under section 519B.5.

b. The attorney general shall represent the fund when a trial court determination is necessary to resolve a claim against the patient compensation fund.

5. *a.* Claims for payment from the patient compensation fund shall be computed and paid not later than sixty days after the issuance of a court-approved settlement or final nonappealable judgment.

b. If the balance in the fund is insufficient to pay in full all claims that have become final during a three-month period, the amount to each claimant shall be prorated. Any amount left unpaid as a result of the proration shall be paid before the payment of claims that become final during the following three-month period.

c. The treasurer of state shall issue a warrant in the amount of each claim submitted to the treasurer against the fund not later than sixty days after the issuance of a court-approved settlement or final nonappealable judgment. The only claim against the fund shall be a voucher or other appropriate request by the commissioner after the commissioner receives one of the following:

(1) A certified copy of a final nonappealable judgment against a health care provider qualified under this chapter.

(2) A certified copy of a court-approved settlement against a health care provider qualified under this chapter.

Sec. 7. NEW SECTION. **519B.7 Statute of limitations.**

1. *a.* This section applies to all persons regardless of minority or other legal disability, except as provided in subsection 3.

b. Notwithstanding section 614.1, subsection 9, or any other provision of law to the contrary, a claim, whether in contract or tort, shall not be brought against a health care provider qualified under this chapter based upon professional services or health care that was provided or that should have been provided unless the claim is brought within two years after the date of the alleged act, omission, or neglect, except that a minor less than six years of age has until the minor's eighth birthday to bring such claim.

c. If a patient meets the criteria stated in section 519B.8, subsection 5, paragraph "*c*", the applicable limitations period is equal to the period that would otherwise apply to the person under subsection 2 plus one hundred eighty days.

2. Notwithstanding section 614.1, subsection 9, section 519B.2, or any other provision of law to the contrary, any claim, whether in contract or tort, by a minor or other person under legal disability against a health care provider qualified under this chapter stemming from professional services or health care provided based on an alleged act, omission, or neglect that occurred before January 1, 2018, shall be brought only within the longer of either of the following:

a. Two years after January 1, 2018.

b. The period described in subsection 1.

3. *a.* The filing of a proposed complaint under section 519B.8 tolls the applicable statute of limitations to and including a period of ninety days following receipt of the opinion of the medical review panel by the claimant.

b. A proposed complaint under section 519B.8, subsection 5, paragraph "*c*", is considered filed when a copy of the proposed complaint is delivered or mailed by registered or certified mail to the commissioner.

Sec. 8. NEW SECTION. **519B.8 Medical malpractice action — commencement.**

1. A patient or a representative of a patient who has a claim against a health care provider qualified under this chapter for bodily injury or death on account of medical malpractice may file a complaint in any court of law having requisite jurisdiction and may, by demand, exercise the right to a trial by jury.

2. A demand in such a medical malpractice complaint shall not include a dollar amount, but the prayer shall be for such damages as are reasonable in the circumstances.

3. Notwithstanding subsection 1, an action for medical malpractice against a health care provider qualified under this chapter shall not be commenced in a court in this state until the claimant's proposed complaint has been filed with the commissioner and presented to a medical review panel established under section 519B.10 and an opinion on the complaint has been rendered by the panel.

4. Notwithstanding subsection 3, a claimant may commence an action in court for medical malpractice against a health care provider qualified under this chapter without presentation of the claim to a medical review panel if the claimant and all parties named as defendants in the action agree that the claim is not to be presented to a medical review panel. The agreement shall be in writing and shall be signed by each party or an authorized agent of the party. The claimant shall attach a copy of the agreement to the complaint filed with the court in which the action is commenced.

5. *a.* Notwithstanding subsection 3, a patient may commence an action against a health care provider qualified under this chapter for medical malpractice without submitting a proposed complaint to a medical review panel if the patient's pleadings include a declaration that the patient seeks damages from the health care provider in an amount not greater than fifteen thousand dollars. In an action commenced under this

subsection, the patient is barred from recovering any amount greater than fifteen thousand dollars except as provided in paragraph "*b*".

b. A patient who commences an action under paragraph "*a*" in the reasonable belief that damages in an amount not greater than fifteen thousand dollars are adequate compensation for the bodily injury allegedly caused by the health care provider's medical malpractice and later learns, during the pendency of the action, that the bodily injury is more serious than previously believed and that fifteen thousand dollars is insufficient compensation for the bodily injury, may move that the action be dismissed without prejudice, and upon dismissal of the action, may file a proposed complaint subject to subsection 3 based upon the same allegations of medical malpractice that were asserted in the action dismissed under this paragraph. However, a patient may move for dismissal without prejudice and, if dismissal without prejudice is granted, may commence a second action under this paragraph only if the patient's motion for dismissal is filed within two years after commencement of the original action under paragraph "*a*".

c. If a patient commences an action under paragraph "*a*", moves for dismissal of that action under paragraph "*b*", files a proposed complaint subject to subsection 3 based on the same allegations of malpractice as were asserted in the action dismissed under paragraph "*b*", and commences a second action following the medical review panel proceeding on the proposed complaint, the timeliness of the second action is governed by the provisions of section 519B.7.

d. A medical malpractice insurer of a health care provider against whom an action has been filed under paragraph "*a*" shall provide written notice to the commissioner.

6. If action has not been taken in a case before the commissioner for a period of at least two years, the commissioner may, on the motion of a party or on the commissioner's own initiative, file a motion in the Polk county

district court to dismiss the case.

Sec. 9. NEW SECTION. **519B.9 Reporting and review of claims.**

1. Within ten days after receiving a proposed complaint under section 519B.8, the commissioner shall forward a copy of the complaint by registered or certified mail to each health care provider qualified under this chapter who is named as a defendant, at the defendant's last and usual place of residence or the defendant's office.

2. A medical malpractice insurer of a health care provider qualified under this chapter against whom an action has been filed pursuant to section 519B.8, subsection 5, shall provide written notice to the commissioner within thirty days after both of the following:

a. The filing of the action.

b. The final disposition of the action.

3. *a.* A medical malpractice insurer shall notify the commissioner of any malpractice case upon which the insurer has placed a reserve of at least one hundred twenty-five thousand dollars, immediately after placing the reserve. The notice and all communications and correspondence relating to the notice are confidential and shall not be made available to any person or any other public or private agency.

b. All malpractice claims settled or adjudicated to final judgment against a health care provider qualified under this chapter shall be reported to the commissioner by the plaintiff's attorney and by the health care provider or the health care provider's medical malpractice insurer within sixty days following final disposition of the claim. The report to the commissioner shall include all of the following information:

(1) The nature of the claim.

(2) The damages asserted and the alleged injury.

(3) The attorney fees and expenses incurred in connection with the claim or defense.

(4) The amount of the settlement or judgment.

4. *a.* A medical review panel established pursuant to section 519B.10 shall make a separate determination, at the time the panel renders an opinion, as to whether the name of the defendant health care provider should be forwarded to the appropriate board of professional regulation for review of the health care provider's fitness to practice the health care provider's profession. The commissioner shall forward the name of the defendant health care provider if the medical review panel unanimously determines that the name should be forwarded. The medical review panel determination concerning the forwarding of the name of a defendant health care provider is not admissible as evidence in a civil action. In each case involving review of a health care provider's fitness to practice that is forwarded under this subsection, the appropriate board of professional regulation may, in appropriate cases, take any disciplinary actions within the authority of that board against the health care provider.

b. The appropriate board of professional regulation shall report to the commissioner the board's findings, the action taken, and the final disposition of each case involving review of a health care provider's fitness to practice forwarded under this subsection.

Sec. 10. NEW SECTION. **519B.10 Medical review panel.**

1. A medical review panel may be established for the purpose of reviewing a proposed malpractice complaint against a health care provider qualified under this chapter.

2. Not earlier than twenty days after the filing of a proposed complaint under section 519B.8, either party to the complaint may request the formation of a medical review panel by serving a request by registered or certified mail upon all parties and the commissioner.

3. A medical review panel established pursuant to this section shall consist of one attorney and three health care providers.

a. The attorney member of the medical review panel shall

act as the chair of the panel and in an advisory capacity as a nonvoting member.

b. The chair of the medical review panel shall expedite the selection of the other panel members, convene the panel, and expedite the panel's review of the proposed complaint. The chair shall establish a reasonable schedule for submission of evidence to the medical review panel that allows sufficient time for the parties to make full and adequate presentation of related facts and authorities.

4. A medical review panel chair shall be selected as follows:

a. Within fifteen days after the filing of a request for formation of a medical review panel under subsection 2, the parties shall select a panel chair by agreement. If no agreement on a panel chair can be reached, either party may request the clerk of the supreme court to draw at random a list of five names of attorneys who meet the following requirements:

(1) Are qualified to practice.

(2) Are presently licensed to practice in the state.

(3) Maintain offices in the county of venue designated in the proposed complaint or in a contiguous county.

b. Before selecting the random list, the clerk shall collect a fee, as provided by rules adopted under chapter 17A, from the party making the request for the formation of the random list.

c. The clerk shall notify the parties, and the parties shall then strike names alternately, with the plaintiff striking first, until one name remains. The remaining attorney shall be the chair of the panel.

d. After the striking procedure, the plaintiff shall notify the chair and all other parties of the name of the chair selected.

e. If a party does not strike a name from the list within five days after receiving notice from the clerk, the opposing party shall, in writing, request the clerk to strike for the party and the clerk shall strike for the party.

f. When one name remains, the clerk shall within five days notify the chair and all other parties of the name of the chair.

g. Within fifteen days after being notified by the clerk of being selected as chair, the chair shall do one of the following:

(1) Send a written acknowledgment of appointment to the clerk.

(2) Show good cause for relief from serving as provided in subsection 7.

5. Health care providers shall be selected for a medical review panel as follows:

a. Except for health care providers who are health facility administrators, all health care providers in the state, whether in the teaching profession or otherwise, shall be available for selection as members of a medical review panel. A health facility administrator shall not be a member of a medical review panel.

b. Each party to the action has the right to select one health care provider, and upon selection, the two health care providers selected shall select a third health care provider to be a panelist.

c. If there are multiple plaintiffs or defendants, only one health care provider shall be selected per side. The plaintiff, whether single or multiple, has the right to select one health care provider, and the defendant, whether single or multiple, has the right to select one health care provider.

d. Notwithstanding paragraph *"c"*, if there is only one party defendant and that defendant is an individual, two of the panelists selected shall be members of the profession of which the defendant is a member. If the individual defendant is a health care provider who specializes in a limited area, two of the panelists selected shall be health care providers who specialize in the same area as the defendant.

e. Within fifteen days after the chair of the panel is

selected, both parties shall select a health care provider and the parties shall notify the other party and the chair of their selection. If a party fails to make a selection within the time provided, the chair shall make the selection and notify both parties. Within fifteen days after their selection, the health care provider members shall select the third member within the time provided and notify the chair and the parties. If the providers fail to make a selection, the chair shall make the selection and notify both parties.

f. Within ten days after the selection of a panel member, written challenge without cause may be made to the panel member. Upon challenge or excuse, the party whose appointee was challenged or dismissed shall select another panelist. If the challenged or dismissed member was selected by the other two panel members, the panel members shall make a new selection. If two such challenges are made and submitted, the chair shall within ten days appoint a panel consisting of three qualified panelists and each side shall, within ten days after the appointment, strike one panelist. The party whose appointment was challenged shall strike last, and the remaining member shall serve.

6. When a medical review panel is formed, the chair shall, within five days, notify the commissioner and the parties by registered or certified mail of the names and addresses of the panel members and the date on which the last member was selected.

7. *a.* A member of a medical review panel who is selected under this chapter shall serve unless either of the following occurs:

(1) The parties by agreement excuse the panelist.

(2) The panelist is excused as provided in this subsection for good cause shown.

b. To show good cause for relief from serving, the attorney selected as chair of the medical review panel shall serve an affidavit upon the clerk of the supreme court that sets out the

facts showing that service would constitute an unreasonable burden or undue hardship. Upon such a showing, the clerk shall excuse the attorney from serving. The attorney shall notify all parties that the attorney is excused and the parties shall then select a new chair as provided in subsection 4.

c. To show good cause for relief from serving, a health care provider member of a medical review panel shall serve an affidavit upon the panel chair. The affidavit shall set out the facts showing that service would constitute an unreasonable burden or undue hardship. Upon such a showing, the chair shall excuse the member from serving. The chair shall notify all parties that the member is excused and the parties shall select a new member as provided in subsection 5.

8. *a.* The panel shall render its expert opinion within one hundred eighty days after the selection of the last member of the initial panel. However, the panel has ninety days after the selection of a new panel member to render its expert opinion if either of the following occurs:

(1) The chair of the panel is removed under subsection 10, another member of the panel is removed under subsection 11, or any member of the panel, including the chair, is removed by a court order.

(2) A new member is selected to replace the removed member more than ninety days after the last member of the initial panel is selected.

b. If the panel does not render an opinion within the time allowed under paragraph *"a"*, the panel shall submit a report to the commissioner, stating the reasons for the delay.

9. A party, attorney, or panelist who fails to act as required by this section without good cause is subject to mandate or appropriate sanctions upon application to the court designated in the proposed complaint as having jurisdiction.

10. The commissioner may remove the chair of the panel if the commissioner determines that the chair is not fulfilling the duties imposed upon the chair by this section. If the

chair is removed under this subsection, a new chair shall be selected as required in this section.

11. The chair of the panel may remove a member of the panel if the chair determines that the member is not fulfilling the duties imposed upon a panel member by this chapter. If a member is removed under this subsection, a new member shall be selected as required in this section.

12. *a.* The evidence in written form to be considered by the medical review panel shall be promptly submitted by the respective parties.

(1) The evidence may consist of medical charts, x-rays, lab tests, excerpts of treatises, depositions of witnesses including parties, and any other form of evidence allowed by the medical review panel.

(2) Depositions of parties and witnesses may be taken before the convening of the panel.

b. The chair shall ensure that before the panel renders its expert opinion under subsection 17, each panel member has the opportunity to review every item of evidence submitted by the parties.

c. Before considering any evidence or deliberating with other panel members, each member of the medical review panel shall take an oath in writing on a form provided by the panel chair which shall read as follows:

"I swear under penalty of perjury that I will well and truly consider the evidence submitted by the parties; that I will render my opinion without bias, based upon the evidence submitted by the parties; and that I have not and will not communicate with any party or representative of a party before rendering my opinion, except as authorized by law."

13. A party, a party's agent, a party's attorney, or a party's malpractice insurer shall not communicate with any member of the panel, except as authorized by law, before the panel renders an expert opinion under subsection 17.

14. The chair of the panel shall advise the panel relative

to any legal question involved in the review proceeding and shall prepare the opinion of the panel as provided in subsection 17.

15. Either party, after submission of all evidence and upon ten days' notice to the other side, has the right to convene the panel at a time and place agreeable to the members of the panel. Either party may question the panel concerning any matters relevant to issues to be decided by the panel before the issuance of the panel's report. The chair of the panel shall preside at all meetings convened pursuant to this subsection and the meetings shall be informal.

16. *a.* The panel has the right and duty to request all necessary information.

b. The panel may consult with medical authorities.

c. The panel may examine reports of other health care providers necessary to fully inform the panel regarding the issue to be decided.

d. Both parties shall have full access to any material submitted to the panel.

17. *a.* The panel has the sole duty to express the panel's expert opinion as to whether or not the evidence supports the conclusion that the defendant or defendants acted or failed to act within the appropriate standards of care as charged in the proposed complaint.

b. After reviewing all evidence and after any examination of the panel by counsel representing either party, the panel shall, within thirty days, render one or more of the following expert opinions, which shall be in writing and signed by the panelists:

(1) The evidence supports the conclusion that the defendant or defendants failed to comply with the appropriate standard of care as charged in the proposed complaint.

(2) The evidence does not support the conclusion that the defendant or defendants failed to comply with the appropriate standard of care as charged in the proposed complaint.

(3) There is a material issue of fact, not requiring expert opinion, bearing on liability for consideration by the court or jury.

(4) The conduct complained of was or was not a factor in the resultant damages, and if so, whether the plaintiff suffered either of the following:

(a) Any disability and the extent and duration of the disability.

(b) Any permanent impairment and the percentage of impairment.

18. A report of the expert opinion rendered by the medical review panel is admissible as evidence in any action subsequently brought by the plaintiff in a court of law. However, the expert opinion is not conclusive, and either party, at the party's cost, has the right to call any member of the medical review panel as a witness. If called as a witness, the member shall appear and testify.

19. A panelist has absolute immunity from civil liability for all communications, findings, opinions, and conclusions made in the course and scope of duties prescribed by this chapter.

20. *a.* Each health care provider member of the medical review panel is entitled to be paid the following:

(1) Up to three hundred fifty dollars for all work performed as a member of the panel, exclusive of time involved if called as a witness to testify in court.

(2) Reasonable travel expenses.

b. The chair of the panel is entitled to be paid the following:

(1) The rate of two hundred fifty dollars per diem, not to exceed two thousand dollars.

(2) Reasonable travel expenses.

c. The chair shall keep an accurate record of the time and expenses of all members of the panel. The records shall be submitted to the parties for payment with the panel's report.

d. Fees of the panel, including travel expenses and other expenses of the review, shall be paid by the side in whose favor the majority opinion is rendered. If there is not a majority opinion, each side shall pay fifty percent of the fees.

21. The chair shall submit a copy of the panel's report to the commissioner and to all parties and attorneys by registered or certified mail within five days after the panel renders its opinion.

Sec. 11. NEW SECTION. **519B.11 Preliminary determination of affirmative defense or issue of law or fact — discovery.**

1. *a.* A court having jurisdiction over the subject matter and the parties to a proposed complaint filed with the commissioner under this chapter may, upon the filing of a copy of the proposed complaint and a written motion made under this section, do any of the following:

(1) Preliminarily determine an affirmative defense or issue of law or fact that may be preliminarily determined under the Iowa rules of civil procedure.

(2) Compel discovery in accordance with the Iowa rules of civil procedure.

b. The court has no jurisdiction to rule preliminarily upon any affirmative defense or issue of law or fact reserved for written expert opinion by the medical review panel under section 519B.10, subsection 17, paragraph *"b"*, subparagraph (1), (2), or (4).

c. The court has jurisdiction to entertain a motion filed under this subsection only during that time after a proposed complaint is filed with the commissioner under section 519B.8, but before the medical review panel renders the panel's opinion under section 519B.10, subsection 17.

d. The failure of any party to move for a preliminary determination or to compel discovery under this subsection before the medical review panel renders the panel's written opinion under section 519B.10, subsection 17, does not

constitute the waiver of any affirmative defense or issue of law or fact.

2. *a.* A party to a proceeding commenced under this chapter, the commissioner, or the chair of a medical review panel, if any, may invoke the jurisdiction of the court by paying the required filing fee to the clerk and filing a copy of the proposed complaint and motion with the clerk.

b. The filing of a copy of the proposed complaint and motion with the clerk confers jurisdiction upon the court over the subject matter and the parties to the proceeding for the limited purposes stated in this section, including the taxation and assessment of costs or the allowance of expenses, including reasonable attorney fees, or both.

c. The moving party or the moving party's attorney shall cause as many summonses as are necessary to be issued by the clerk and served on the commissioner, each nonmoving party to the proceedings, and the chair of the medical review panel, if any, unless the commissioner or the chair is the moving party, together with a copy of the proposed complaint and a copy of the motion pursuant to the Iowa rules of civil procedure.

3. *a.* Each nonmoving party to the proceeding, including the commissioner and the chair of the medical review panel, if any, shall have a period of twenty days after service to appear and file and serve a written response to the motion, unless the court, for cause shown, orders the period enlarged.

b. The court shall enter a ruling on the motion as follows:

(1) Within thirty days after the motion is heard.

(2) If no hearing is requested, granted, or ordered, within thirty days after the date on which the last written response to the motion is filed.

c. The court shall order the clerk to serve a copy of the proposed complaint and motion by ordinary mail on the commissioner, each party to the proceeding, and the chair of the medical review panel.

4. Upon the filing of a copy of the proposed complaint and

motion with the clerk of court, all further proceedings before the medical review panel shall be automatically stayed until the court has entered a ruling on the motion.

5. The court may enforce its ruling on any motion filed under this section in accordance with the Iowa rules of civil procedure.

Sec. 12. NEW SECTION. **519B.12 Liability based on breach of contract — informed consent.**

1. Liability shall not be imposed on a health care provider qualified under this chapter on the basis of an alleged breach of contract, express or implied, assuring results to be obtained from any treatment, procedure, examination, or test undertaken in the course of health care, unless the contract is in writing and signed by that health care provider or by an authorized agent of the health care provider.

2. For purposes of this chapter, a rebuttable presumption is created that consent to any treatment, procedure, examination, or test undertaken in the course of health care is informed consent if a patient's written consent meets all of the following requirements:

a. Is signed by the patient or the patient's authorized representative.

b. Is witnessed by an individual at least eighteen years of age.

c. Is explained, orally or in the written consent, to the patient or the patient's authorized representative before a treatment, procedure, examination, or test is undertaken.

3. The explanation required in subsection 2, paragraph "*c*", shall include all of the following information:

a. The general nature of the patient's condition.

b. The proposed treatment, procedure, examination, or test.

c. The expected outcome of the treatment, procedure, examination, or test.

d. The reasonable alternatives to the treatment, procedure, examination, or test.

4. This section does not do any of the following:

a. Relieve a health care provider qualified under this chapter of the duty to obtain an informed consent.

b. Prevent a patient, after having signed a consent, from withdrawing that consent.

c. Require that a patient's consent or the information described in subsection 3 be in writing in all cases.

5. Compliance with this chapter is not required to create an informed consent.

6. A patient may refuse to receive some or all of the information described in subsection 3.

7. Subsections 2 and 3 do not apply to a person who is mentally incapable of understanding the information required to be provided in subsection 3.

8. This section does not require consent to health care in an emergency.

Sec. 13. NEW SECTION. **519B.13 Malpractice coverage.**

1. The liability of a health care provider qualified under this chapter and the health care provider's medical malpractice insurer to a patient or the patient's representative for malpractice is limited to the extent and in the manner specified in this chapter only while medical malpractice insurance remains in force.

2. The establishment of financial responsibility with the commissioner pursuant to section 519B.4 constitutes, on the part of the medical malpractice insurer, a conclusive and unqualified acceptance of the provisions of this chapter.

3. A provision in a medical malpractice insurance policy that attempts to limit or modify the liability of an insurer contrary to the provisions of this chapter is void.

4. Every policy of medical malpractice insurance issued pursuant to this chapter is deemed to include the following provisions, and any changes made by legislation adopted by the general assembly, as fully as if the provision or change were written in the policy:

a. The insurer assumes all obligations to pay an award imposed against its insured under this chapter.

b. A termination of a medical malpractice insurance policy by cancellation initiated by the insurer is not effective for patients claiming against the insured covered by the policy unless at least thirty days before the cancellation takes effect, a written notice giving the date upon which the termination becomes effective has been received by the insured and the commissioner at their offices.

c. A termination of a medical malpractice insurance policy by cancellation initiated by the insured is not effective for patients claiming against the insured covered by the policy unless at least thirty days before the cancellation takes effect, a written notice giving the date upon which the termination becomes effective has been received by the commissioner at the commissioner's offices.

5. If a medical malpractice insurer fails or refuses to pay a final judgment, except during the pendency of an appeal, or fails or refuses to comply with the provisions of this chapter, in addition to any other legal remedy, the commissioner may also revoke the approval of the insurer's policy form until the insurer pays the award or judgment or has complied with any other provision of this chapter and has resubmitted its policy form and received the approval of the commissioner.

Sec. 14. NEW SECTION. **519B.14 Limits on damages.**

1. *a.* The total amount recoverable in an action under this chapter for an injury to or death of a patient shall not exceed one million two hundred fifty thousand dollars for an act of malpractice that occurs after January 1, 2018.

b. A health care provider qualified under this chapter is not liable for an amount in excess of two hundred fifty thousand dollars for an occurrence of malpractice.

c. Any amount due from a judgment or settlement that is in excess of the total liability of all liable health care providers, subject to paragraph "*a*", "*b*", or "*d*", shall be paid

from the patient compensation fund under section 519B.6.

d. If a health care provider qualified under this chapter admits liability or is adjudicated liable solely by reason of the conduct of another health care provider who is an officer, agent, or employee of the health care provider acting in the course and scope of employment and qualified under this chapter, the total amount that shall be paid to the claimant on behalf of the officer, agent, or employee and the health care provider by the health care provider or the provider's medical malpractice insurer is two hundred fifty thousand dollars. The balance of an adjudicated amount to which the claimant is entitled shall be paid by the other liable health care providers or from the patient compensation fund, or both.

2. *a.* If the possible liability of a health care provider to a patient is discharged solely through an immediate payment, the limitations on recovery from a health care provider stated in subsection 1, paragraphs *"b"* and *"d"*, apply without adjustment.

b. If the health care provider agrees to discharge its possible liability for the patient through a periodic payments agreement, the amount of the patient's recovery from a health care provider in a case under this subsection is the amount of any immediate payment made by the health care provider or the health care provider's insurer to the patient, plus the cost of the periodic payments agreement to the health care provider or the health care provider's insurer. For the purpose of determining the limitations on recovery stated in subsection 1, paragraphs *"b"* and *"d"*, and for the purpose of determining the question under section 519B.15 of whether the health care provider or the health care provider's insurer has agreed to settle its liability by payment of its policy limits, the sum of both of the following must exceed one hundred eighty-seven thousand dollars:

(1) The present payment of moneys to the patient or the patient's estate by the health care provider or the health care

provider's insurer.

(2) The cost of the periodic payments agreement expended by the health care provider or the health care provider's insurer.

c. More than one health care provider may contribute to the cost of a periodic payments agreement, and in such an instance the sum of the amounts expended by each health care provider for immediate payment and for the cost of the periodic payments agreement shall be used to determine whether the one hundred eighty-seven thousand dollar requirement in paragraph "*b*" has been satisfied. However, one health care provider or the health care provider's insurer must be liable for at least fifty thousand dollars.

3. *a.* If the possible liability of the patient compensation fund to the patient is discharged solely through a direct payment made under section 519B.15, the limitations on recovery from the patient compensation fund apply without adjustment.

b. If an agreement is made to discharge the fund's possible liability to the patient through a periodic payments agreement, the amount of the patient's recovery from the fund for the purpose of the limitation on recovery from the fund is the sum of the following:

(1) The amount of any immediate payment made directly to the patient from the fund.

(2) The cost of the periodic payments agreement paid by the commissioner on behalf of the fund.

Sec. 15. NEW SECTION. **519B.15 Payment from patient compensation fund.**

1. An obligation to pay an amount from the patient compensation fund may be discharged as follows:

a. Payment in one lump amount.

b. An agreement requiring periodic payments from the fund over a period of years.

c. The purchase of an annuity payable to the patient.

d. Any combination of payments made pursuant to paragraph "*a*", "*b*", or "*c*".

2. The commissioner may contract with approved insurers to ensure the ability of the fund to make periodic payments under subsection 1, paragraph "*b*".

3. Notwithstanding section 519B.16, the commissioner may do any of the following:

a. Discharge the possible liability of the patient compensation fund to a patient through a periodic payments agreement.

b. Combine moneys from the patient compensation fund with moneys of the health care provider or the provider's insurer to pay the cost of the periodic payments agreement with the patient or the patient's estate. However, the amount provided by the commissioner shall not exceed eighty percent of the total amount expended for the agreement.

4. If a health care provider or the provider's insurer has agreed to settle the provider's liability on a claim by payment of the policy limits of two hundred fifty thousand dollars, and the claimant is demanding an amount in excess of that amount, the following procedure shall be followed:

a. A petition shall be filed by the claimant in the court named in the proposed complaint, seeking either of the following:

(1) Approval of an agreed settlement, if any.

(2) Payment of a demand for damages from the patient compensation fund.

b. A copy of the petition with summons shall be served on the commissioner, the health care provider, and the health care provider's insurer, and shall contain sufficient information to inform the other parties about the nature of the claim and the additional amount demanded.

c. The commissioner and either the health care provider or the provider's insurer may agree to a settlement with the claimant from the patient compensation fund, or the commissioner, the health care provider, or the provider's insurer may file written objections to payment of the amount

demanded. The agreement or objections to the payment demanded shall be filed within twenty days after service of a summons with a copy of the petition attached.

d. The judge of the court in which the petition is filed shall set the petition for approval or, if objections have been filed, for hearing as soon as practicable. The court shall give notice of the hearing to the claimant, the health care provider, the provider's insurer, and the commissioner.

e. At the hearing, the commissioner, the claimant, the health care provider, and the provider's insurer may introduce relevant evidence to enable the court to determine whether or not the petition should be approved if the evidence is submitted on agreement without objections. If the commissioner, the health care provider, the provider's insurer, and the claimant cannot agree on the amount, if any, to be paid out of the patient compensation fund, the court shall, after hearing any relevant evidence on the issue of the claimant's damages submitted by any of the parties described in this paragraph, determine the amount of the claimant's damages, if any, in excess of the two hundred fifty thousand dollars already paid by the insurer of the health care provider. The court shall determine the amount for which the fund is liable and make a finding and judgment accordingly. In approving a settlement or determining the amount, if any, to be paid from the patient compensation fund, the court shall consider the liability of the health care provider as admitted and established.

f. A settlement approved by the court is not subject to appeal. A judgment of the court fixing damages recoverable in a contested proceeding is appealable pursuant to the rules governing appeals in any other civil case tried by the court.

g. A release executed between the parties does not bar access to the patient compensation fund unless the release specifically provides otherwise.

5. If a health care provider or the health care provider's

surety or liability insurance carrier fails to pay any agreed settlement or final judgment within ninety days, the agreed settlement or final judgment shall be paid from the patient compensation fund, and the fund shall be subrogated to any and all of the claimant's rights against the health care provider, the health care provider's surety or liability insurance carrier, or both, with interest, reasonable costs, and attorney fees.

Sec. 16. NEW SECTION. **519B.16 Evidence of advance payment — assignability of claim.**

1. Except as provided in section 519B.15, any advance payment made by the defendant health care provider or the health care provider's insurer to or for the plaintiff or any other person shall not be construed as an admission of liability for injuries or damages suffered by the plaintiff or anyone else in an action brought for medical malpractice.

2. *a.* Evidence of an advance payment is not admissible until there is a final judgment in favor of the plaintiff. In this case, the court shall reduce the judgment to the plaintiff to the extent of the advance payment. The advance payment inures to the exclusive benefit of the defendant or the defendant's insurer making the payment.

b. If the advance payment exceeds the liability of the defendant or the insurer making the advance payment, the court shall order any adjustment necessary to equalize the amount that each defendant is obligated to pay, exclusive of costs. An advance payment in excess of an award is not repayable by the person receiving the advance payment.

3. A patient's claim for compensation under this chapter is not assignable.

Sec. 17. NEW SECTION. **519B.17 Attorney fees.**

1. When a plaintiff is represented by an attorney in the prosecution of the plaintiff's claim, the plaintiff's attorney fees from any award made from the patient compensation fund shall not exceed fifteen percent of any recovery from the fund.

2. A patient has the right to elect to pay for an attorney's services on a mutually satisfactory per diem basis. The election, however, shall be exercised in written form at the time of employment of the attorney.

EXPLANATION

The inclusion of this explanation does not constitute agreement with the explanation's substance by the members of the general assembly.

This bill creates new Code chapter 519B relating to medical malpractice liability and insurance coverage in the state.

The bill applies to health care providers, including individuals, hospitals, and health care facilities, that qualify under the new Code chapter by establishing financial responsibility and paying a surcharge. A health care provider establishes financial responsibility by filing proof with the commissioner of insurance that the provider has medical malpractice insurance coverage of at least $250,000 per occurrence and $750,000 in the annual aggregate. Health care providers that are hospitals or health care facilities are subject to different amounts based on the number of beds. Financial responsibility can also be established by filing and maintaining a surety bond, or if the provider is a hospital, by submitting a verified financial statement.

Beginning January 1, 2018, the bill provides that an annual surcharge shall be assessed on all health care providers that seek to qualify under new Code chapter 519B in the state to create a source of moneys for a patient compensation fund. Beginning January 1, 2018, the amount of the annual surcharge is 100 percent of the cost to each provider of maintaining financial responsibility except that surcharges assessed against physicians and hospitals are based on calculations of actuarial risk. Beginning January 1, 2020, the annual surcharge is to be set by rules adopted by the commissioner that meet specified requirements. The surcharge is collected on the same basis as premiums by each medical malpractice insurer and remitted by each insurer to the commissioner for

deposit into the patient compensation fund.

The patient compensation fund is established under the custody of the treasurer of state and consists of payments to the fund as well as accumulated interest and earnings. Moneys in the fund shall be disbursed only for the purposes set forth in the bill, including reimbursements to the attorney general for representing the fund.

The bill provides that a patient must file a malpractice claim within two years from the alleged act of malpractice against a health care provider that has qualified under the bill's provisions. However, minors under the age of six have until their eighth birthday to file.

An action for medical malpractice against a health care provider who has qualified under the provisions of the bill cannot be commenced in court until the claimant's proposed complaint has been presented to a medical review panel and an opinion on the complaint has been rendered by the panel. However, the parties can commence an action in court if the parties agree to forgo submission to a medical review panel or the claimant seeks damages of $15,000 or less.

Within 10 days after receiving a proposed complaint, the commissioner must forward a copy of the complaint to each health care provider named as a defendant. A medical review panel may be established for the purpose of reviewing a proposed malpractice complaint against a health care provider qualified under the new Code chapter. Either party to the proposed complaint can request the formation of a medical review panel.

A medical review panel consists of one attorney, who acts as the chair and is a nonvoting member, and three health care providers. The attorney member is selected by the parties, but if they cannot agree, then the clerk of the supreme court generates a random list of five attorneys from which the parties strike names alternately until one name remains.

All health care providers in the state, except health care

facility administrators, must be available for selection as panel members. Each party to the action is entitled to select one health care provider, and upon selection, the two health care providers select a third health care provider to complete the panel. If there is a single defendant, two of the panelists must be in the same health care profession as the defendant. If the defendant specializes in a limited area, two of the panelists must be specialists in that area.

The medical review panel is required to render an expert opinion within 180 days after the selection of the last member of the initial panel, or submit a report to the commissioner stating the reason for the delay. Evidence that may be submitted to the panel includes medical charts, x-rays, lab tests, excerpts of treatises, depositions of witnesses, including parties, and any other form of evidence allowed by the panel. The panel may consult with medical authorities and examine reports of other health care providers for information.

The chair of the panel provides advice on any legal questions involved in the review and prepares the panel's opinion. Any party may informally convene the panel to question the panel about issues to be decided.

Thirty days after completing its review, the panel must render one or more of the following expert opinions: (1) the evidence supports the conclusion that the defendant failed to comply with the appropriate standard of care; (2) the evidence does not support the conclusion that the defendant failed to meet the appropriate standard of care; (3) there is a material issue of fact not requiring expert opinion, bearing on liability, for consideration by the court or jury; or (4) the conduct complained of was or was not a factor in the resultant damages and if so, any disability and its extent and duration, and any permanent impairment and its percentage.

A report of the medical review panel is admissible in evidence in any action subsequently brought by the plaintiff in a court of law, although the expert opinion rendered is not

conclusive. Panelists have absolute immunity from liability for performing their duties. The bill specifies payment for panelists and the chair.

The bill provides that a health care provider qualified under the new Code chapter is not liable for an amount in excess of $250,000 for an occurrence of malpractice. The total amount recoverable for an injury or death of a patient cannot exceed $1.25 million for an act of malpractice that occurs after January 1, 2018. Any amount due against a health care provider in excess of $250,000 and up to the capped amount is paid from the patient compensation fund. Payments from the patient compensation fund can be made in one lump sum, by an agreement to make periodic payments over a period of years, by purchase of an annuity payable to the patient, or by any combination of the above. When a patient is represented by an attorney in the prosecution of the patient's claim, that attorney's fees from any award from the patient compensation fund cannot exceed 15 percent of the recovery. A patient may elect to pay the attorney on a mutually satisfactory per diem basis pursuant to a written agreement.